

**JUDGE SAND**

**UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF NEW YORK**

**08 CV 6968**

THE LINCOLN NATIONAL LIFE INSURANCE  
COMPANY,

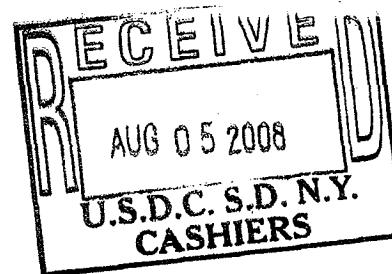
Plaintiff,

Case No.:

v.

HENRY COHEN, as Trustee of  
The Shirley Friedberger Irrevocable Insurance  
Trust, and WENDY TITTEL, as Beneficiary of  
The Shirley Friedberger Irrevocable Insurance  
Trust,

Defendants.



**COMPLAINT FOR DECLARATORY JUDGMENT**

Plaintiff, The Lincoln National Life Insurance Company, as successor by merger to Jefferson-Pilot Life Insurance Company ("Lincoln"), by and through its attorneys, hereby files this Complaint for Declaratory Judgment, and in support thereof, avers as follows:

1. This is an action for Declaratory Judgment under 28 U.S.C. § 2201. Lincoln seeks a declaration establishing its rights and obligations pursuant to a policy of life insurance issued to The Shirley Friedberger Irrevocable Insurance Trust (the "Trust"), which policy has a face value of \$4 million. Lincoln is entitled to declaratory relief because the policy applicants made one or more material misrepresentations to Lincoln in applying for the policy.

**PARTIES**

2. Plaintiff Lincoln is a life insurance company organized and existing under the laws of the State of Indiana, with its principal place of business located at 1300 South Clinton Street, Fort Wayne, Indiana 46802.

3. Upon information and belief, Defendant Henry Cohen ("Mr. Cohen" or the "Trustee") is the Trustee of the Trust and a natural person with an address of 30 Ellis Place, Ossining, New York 10562.

4. Upon information and belief, Defendant Wendy Tittel ("Ms. Tittel" or the "Beneficiary") is the Beneficiary of the Trust and a natural person with an address of 30 Ellis Place, Ossining, New York 10562.

**JURISDICTION AND VENUE**

5. This Court has jurisdiction over this matter pursuant to 28 U.S.C. § 1332(a)(1), insofar as the matter in controversy exceeds the sum of \$75,000, exclusive of interest and costs, and there is complete diversity between Plaintiff and Defendants.

6. Venue is proper in this district pursuant to 28 U.S.C. § 1391(a), because at least one defendant resides in this judicial district and all of the defendants reside in the same State, and, further, because a substantial part of the events giving rise to the claim occurred in this judicial district.

**BACKGROUND**

**The Application for the Policy**

7. On June 1, 2007, a formal application (the "Application") was submitted to Lincoln, which proposed a \$4 million insurance policy on the life of Ms. Friedberger. A true and correct copy of the Application, with redactions of certain personal identifiers, private health information and financial account data, is attached hereto as Exhibit "A."

8. In the Application, Ms. Friedberger, who was 83 years old at the time, represented that the owner and beneficiary of the proposed policy would be the Trust. *See Exhibit "A."*

9. The Application contained a section entitled "Medical Information," which required Ms. Friedberger to answer a series of questions regarding her past and present health status. *See Exhibit "A."*

10. In answering the Application's questions regarding her health status, Ms. Friedberger disclosed that she had high blood pressure, diabetes and arthritis, and was taking several medications for these conditions. *See Exhibit "A."*

11. In the Application, Ms. Friedberger denied that she had ever had, or been told by a medical professional to seek treatment because of, any other health impairment, congenital deformity or medically or surgically treated condition not otherwise mentioned in the Application. *See Exhibit "A."*

12. Ms. Friedberger signed the Application and certain associated documents on May 26, 2007 in Lake Worth, Florida and, upon information and belief, forwarded via facsimile the signed Application and associated documents on May 30, 2007 to either her agent, Michael

Binday ("Mr. Binday") in Scarsdale, New York, or to Mr. Cohen, who was also in the State of New York. *See Exhibit "A."*

13. Mr. Cohen, as the Trustee, signed the Application and certain associated documents. *See Exhibit "A."* Upon information and belief, Mr. Cohen signed the Application and associated documents in the State of New York sometime after May 30, 2007, but before the documents were received by Lincoln on June 1, 2007.

14. Ms. Friedberger's agent, Mr. Binday, also signed the Application and certain associated documents. *See Exhibit "A."* Upon information and belief, Mr. Binday signed the Application and certain associated documents in Scarsdale, New York sometime after May 30, 2007, but before the documents were received by Lincoln on June 1, 2007.

15. The Application contains an "Agreement and Acknowledgement" section, which reads, in pertinent part, as follows:

Each of the undersigned (*i.e.*, Ms. Friedberger, Mr. Cohen and Mr. Binday) declares that:

- ...
2. Unless otherwise provided by the Conditional Receipt, the Company will have no liability under this application unless and until: a) it has been received and approved by the Company at its Service Office; b) the policy has been issued and delivered to the policyowner; c) the first premium has been paid to and accepted by the Company; and d) at the time of delivery and payment, the facts concerning the insurability of each person proposed for insurance (*i.e.*, Ms. Friedberger) are as stated in this application.

Exhibit "A" at p. 6.

16. Therefore, in completing and signing the Application, Ms. Friedberger, Mr. Cohen, Mr. Binday and/or those acting for them, knew that they were required to provide

truthful and accurate information regarding the insurability of Ms. Friedberger, not only as of the date of the Application, but also, up to and including the date on which a policy was delivered to Mr. Cohen and payment of the premium was accepted by Lincoln

### **The Underwriting and Issuance of the Policy**

17. Following receipt of the Application, Lincoln, on June 6, 2007, conducted a telephone interview of Ms. Friedberger, at which time Ms. Friedberger stated she was receiving medical treatment only for diabetes and high blood pressure, and that she was taking medications only for these conditions and for arthritis. Ms. Friedberger also advised Lincoln she had been treated for hemorrhoids a few months earlier, but that condition had normalized and she had not been back to the doctor for that condition.

18. On or about July 18, 2007, Lincoln received a physician's statement from Ms. Friedberger's personal physician, Dr. Jeffrey Behrens, dated November 3, 2006, wherein it was reported that Ms. Friedberger had the following medical conditions: high blood pressure, obesity, systolic heart murmur, diabetes, mild aortic stenosis, cardiomegaly, osteoarthritis, rectal bleeding and hemorrhoids. Lincoln updated its underwriting file accordingly.

19. On or about July 20, 2007, Lincoln received a letter from Dr. Geri Abraham at Ms. Friedberger's personal physician's office stating Ms. Friedberger's hemoglobin was lower than the year prior and her heart murmur was stable. This letter was the last of any medical information and/or documentation sent to Lincoln by, or received by Lincoln from, the policy applicants or anyone acting for them, or at their request, in connection with the Application.

20. In reliance upon the Application, including the medical information and/or documentation submitted to, or received by, Lincoln in connection therewith, Lincoln agreed to issue a \$4 million policy on the life of Ms. Friedberger (the "Policy").

21. Lincoln sent the Policy to Ms. Friedberger's agent, Mr. Binday, who then delivered it to Mr. Cohen on September 6, 2007 in the State of New York, at which time both Mr. Cohen, as the Trustee, and Mr. Binday signed a delivery receipt notice, which was then forwarded to Lincoln as confirmation of the delivery of the Policy.

22. On September 7, 2007, Lincoln accepted the Policy's first premium payment, which was in the form of a personal check signed by Ms. Tittel, drawn on her bank account in the State of New York.

23. Having received confirmation that the Policy had been delivered to Mr. Cohen and having accepted the first premium payment, Lincoln issued the Policy on September 7, 2007 (the "Issuance Date").

24. On October 19, 2007, after Ms. Friedberger's death earlier that same day, a claim for the death benefit under the Policy was submitted to Lincoln.

#### **Lincoln's Discovery of Evidence of Material Misrepresentations by the Policy Applicants**

25. Following Ms. Friedberger's death and the filing of a claim for the death benefit under the Policy by the Trust, Lincoln commenced a contestable claim investigation and has learned thereby that the applicants made one or more material misrepresentations regarding the health and insurability of Ms. Friedberger as of the Issuance Date, contrary to the representations in the Application.

26. Lincoln learned that, subsequent to the Application of June 1, 2007 and prior to the Issuance Date, Ms. Friedberger was hospitalized beginning on or about July 19, 2007 and, upon information and belief, she remained either in a hospital or at a nursing home and/or hospice facility until her death on October 19, 2007.

27. Specifically, Lincoln learned the following:

- (a) On July 20, 2007, while hospitalized, Ms. Friedberger was diagnosed with acute renal failure and chronic kidney disease.
- (b) On July 27, 2007, while hospitalized, Ms. Friedberger underwent an OB/GYN consultation, at which time a pelvic exam revealed a palpable anterior vaginal mass, highly suspicious of either vaginal or cervical cancer.
- (c) On August 21, 2007, Ms. Friedberger was transferred from West Boca Medical Center in Boca Raton, Florida to a hospice or nursing home known as Heartland of Boca, where she was admitted for the purpose of receiving care for her medical conditions, which included, but were not limited to, renal insufficiency and cervical cancer.
- (d) On September 7, 2007, Ms. Friedberger was transferred back to West Boca Medical Center with a urinary tract infection, dehydration and bacteremia.
- (e) On September 11, 2007, Ms. Friedberger was transferred from West Boca Medical Center back to Heartland of Boca for further care for her medical conditions, which included, but were not limited to, renal insufficiency and cervical cancer.
- (f) On or about September 28, 2007, Ms. Friedberger was transferred to a hospice facility known as Hospice by the Sea to receive care for her medical conditions, which included, but were not limited to, renal insufficiency and cervical cancer.
- (g) On October 19, 2007 at 5:50 a.m., Ms. Friedberger passed away while at Hospice by the Sea.

28. Lincoln learned the cause of Ms. Friedberger's death was "carcinoma at cervix"

or cervical cancer.

29. At no time between the date of the Application and the Issuance Date did the Policy applicants (*i.e.*, Ms. Friedberger, Mr. Cohen and Mr. Binday), nor anyone acting for them or at their request, inform Lincoln of Ms. Friedberger's hospitalization beginning on or about July 19, 2007, nor did they inform Lincoln of the changes in Ms. Friedberger's health and insurability, which included, but was not limited to, Ms. Friedberger's acute renal failure,

chronic kidney disease, vaginal mass and cervical cancer, thereby misrepresenting one or more facts in the Application concerning the health and insurability of Ms. Friedberger.

30. The misrepresentations set forth in the Application were material, in that they induced Lincoln to issue the Policy and substantially affected the hazard assumed by Lincoln. Had the applicants truthfully and accurately represented the facts on or before the Issuance Date, as required by the Application, Lincoln would not have issued the Policy.

**DECLARATORY JUDGMENT – MATERIAL MISREPRESENTATION**

31. Ms. Friedberger, Mr. Cohen, Mr. Binday and/or others acting for them or at their request, made one or more misrepresentations to Lincoln in the Application, concerning, *inter alia*, the health and insurability of Ms. Friedberger.

32. As of the Issuance Date, Ms. Friedberger, Mr. Cohen, Mr. Binday and/or others acting for them or at their request, knew, or should have known, of the falsity of certain representations made in the Application. The representations made in the Application regarding, *inter alia*, the health and insurability of Ms. Friedberger, were material and induced Lincoln's reliance; indeed the misrepresentations had a significant bearing upon Lincoln's decision to issue the Policy.

33. Lincoln is entitled to a judicial declaration that, pursuant to applicable law, no proper claim for the death benefit or other relief of performance is owed by Lincoln under the Policy, and, further, that the Policy is void *ab initio*, as it was issued by Lincoln in reliance upon one or more material misrepresentations made by the Policy applicants, or in the alternative, that the misrepresentations constitute grounds for rescission of the Policy by Lincoln.

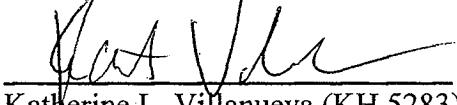
WHEREFORE, Lincoln respectfully requests the entry of an Order by this Court declaring:

- A. Whether by virtue of the misrepresentations aforesaid, no proper claim for the death benefit or other relief of performance is owed by Lincoln under the Policy;
- B. Whether the Policy is void *ab initio*, or in the alternative, whether Lincoln may rescind the Policy, due to one or more of the material misrepresentations made by the Policy applicants in the Application and relied upon by Lincoln;
- C. Whether Lincoln may retain some or all of the premiums paid pursuant to the Policy;
- D. Whether Lincoln is awarded attorney's fees and costs associated with seeking this judgment; and
- E. Whether Lincoln is granted such further relief as this Court deems appropriate.

**DRINKER BIDDLE & REATH LLP**

July \_\_, 2008

By:

  
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*Attorneys for Plaintiff*  
*The Lincoln National Life Insurance Company*

PHLITI/9296483

EXHIBIT "A"



Please check appropriate underwriting company:

- Jefferson Pilot Life Insurance Company, Service Office: PO Box 21008, Greensboro, NC 27429-1008  
 Jefferson Pilot Financial Insurance Company, Service Office: PO Box 515, Concord, NH 03302-0515  
 (hereinafter referred to as "the Company")

## APPLICATION FOR LIFE INSURANCE — PART I

## I. PROPOSED INSURED

1. Name of Proposed Insured	<input type="checkbox"/> Male	<input type="checkbox"/> Female	2. Date of Birth (mm/dd/yy)	3. Place of Birth (State, Country)	4. Social Security Number <b>062-18-3546</b>
<i>Shirley Friedberg</i>			<b>REDACTED</b>	<b>NY, USA</b>	5. Driver License # & State <b>REDACTED</b>
6. Home Address (Street, City/State, Zip Code) <b>REDACTED</b>	<b>Lake Worth, FL 33467</b>			7. Years At This Address <b>12 yrs</b>	
8. Employer <b>REDACTED</b>	9. Business Address (Street, City, State, Zip Code)				
10. Occupation/Duties <i>Real Estate Broker</i>	11. Home Telephone <b>REDACTED</b>	12. Business Telephone	13. Citizen of (Country) <b>USA</b>		

## II. PROPOSED ADDITIONAL INSURED - Complete for Survivorship Life Policy or Term Rider on Spouse/Other Insured for Individual Life Policy.

14. Name of Proposed Insured	<input type="checkbox"/> Male	<input type="checkbox"/> Female	15. Date of Birth (mm/dd/yy)	16. Place of Birth (State, Country)	17. Social Security Number
			18. Driver License # & State		
19. Home Address (Street, City, State, Zip Code)				20. Years At This Address	
21. Employer	22. Business Address (Street, City, State, Zip Code)				
23. Occupation/Duties	24. Home Telephone	25. Business Telephone	26. Citizen of (Country)		

## III. COVERAGE INFORMATION

27. Plan of Insurance (If Ensemble*, also complete Question 32)	28. Amount of Insurance: \$ <b>414,000</b>
<i>Advantage 50+ lives</i>	
29. (i) Death Benefit Option <input checked="" type="checkbox"/> Level <input type="checkbox"/> Increasing <input type="checkbox"/> Specified Amount plus premiums less withdrawals (ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless <input type="checkbox"/> Cash Value Accumulation Test is checked (not available on all products). Cannot be changed after issue.	
30. Additional <input type="checkbox"/> Waiver of Premium	
Benefits: <input type="checkbox"/> Accidental Death Benefit \$ _____	<input type="checkbox"/> Term on Spouse/Other Insured Rider \$ _____
<input type="checkbox"/> Guaranteed Insurability \$ _____	<input type="checkbox"/> Children's Rider \$ _____ / Units _____
<input type="checkbox"/> Waiver of Specified Premium \$ _____	(Complete Child's Supplement)
<input type="checkbox"/> Accelerated Benefit Rider	<input type="checkbox"/> Other _____
<input type="checkbox"/> Supplemental Coverage/	<input type="checkbox"/> Other _____
Additional Specified Amount Rider \$ _____	<input type="checkbox"/> Other _____

31. Automatic Premium Loan  Yes  No (This question applies to Whole Life Nonpar products only.)

32. Complete only if applying for Variable Life Insurance with Jefferson Pilot Financial Insurance Company.

Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:

(i) Monthly insurance and administrative charges will be deducted from the General Account and divisions of the Separate Account on a pro rata basis Unless the box is checked below (not available on all VUL products):

[ ] Deduct all charges from the \_\_\_\_\_ division (any single division or the General Account may be noted).

## (ii) Suitability

- |  | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
|--|---|-----------------------------|
| 1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus dated _____ for the policy applied for and have you had sufficient time to review it? | <input checked="" type="checkbox"/>     | <input type="checkbox"/>    |
| 2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?                                      | <input checked="" type="checkbox"/>     | <input type="checkbox"/>    |
| 3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?  | <input checked="" type="checkbox"/>     | <input type="checkbox"/>    |
| 4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?  | <input checked="" type="checkbox"/>     | <input type="checkbox"/>    |

**CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT.  
THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.**

**IV. OWNER INFORMATION (Complete If Different from Proposed Insured(s))**

33. (i) Owner Name (First, Middle, Last) <i>The Friedberger Irrevocable Insurance Trust</i>	(ii) Citizen of (Country)	
34. Owner Address <i>30 Ellis Place, Ossining NY 10562</i>		
35. Owner Social Security or Tax ID # <i>Pending</i>	36. Relationship to Proposed Insured(s) <i>Trustee</i>	37. Trust Date (only if Trust is Owner) <i>5/24/01</i>

**V. BENEFICIARY DESIGNATION**

38. Primary Beneficiary(ies): <i>The Friedberger Irrevocable Insurance Trust</i>	39. Social Security or Tax ID #: <i>Pending</i>	40. Relationship(s) to Proposed Insured(s): <i>Trustee</i>
41. Contingent Beneficiary(ies):	42. Social Security or Tax ID #:	43. Relationship(s) to Proposed Insured(s):
44. Beneficiary for Spouse/Other Insured Term Rider:	46. Relationship to Spouse/Other Insured:	

45. Social Security or Tax ID #:	
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**VI. BILLING INSTRUCTIONS**

47. Payment with Application \$ <input checked="" type="checkbox"/>	Was the Conditional Receipt Given? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
48. Planned Premium: \$ <i>310,000</i>	49. Lump Sum: \$	<input type="checkbox"/> 1035 Exchange	
50. Premiums to be Paid: <input checked="" type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> List Bill # _____			
<input type="checkbox"/> DRAFT/PAC <input type="checkbox"/> PDF (Complete Transmittal)	<input type="checkbox"/> Other: _____		
51. Premium Bill to be Sent to: <input type="checkbox"/> Proposed Insured at: <input type="checkbox"/> Home Address <input type="checkbox"/> Business Address; or <input type="checkbox"/> Proposed Additional Insured at: <input type="checkbox"/> Home Address <input type="checkbox"/> Business Address; or <input checked="" type="checkbox"/> Owner at address listed in #34	<input type="checkbox"/> Other ("Care Of" Name and Mailing Address)		

## 52. Special Instructions:

Complete each question for the Proposed Insured and any Additional Insured.

VII. PERSONAL FINANCE	Proposed Insured	Additional Insured
53. Annual Earned Income:	a) \$ 35,000	b) \$
54. Annual Unearned Income (if none, please indicate \$0):	a) \$ 25,000	b) \$
55. Total Assets:	a) \$ 900,000	b) \$
56. Total Liabilities:	a) \$ 95,000	b) \$
57. Net Worth:	a) \$ 705,000	b) \$
58. In the last 5 years have you filed for bankruptcy? If "Yes", COMPLETE the Financial Supplement.	a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No

VIII. LIFE INSURANCE IN FORCE

59. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium?	a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
60. Do you have any applications pending with any other life insurance company now?	a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No

If answered "Yes" to question 59-60, please give details here for each Proposed Insured.

Proposed Insured:

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Additional Insured:

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61. i.) Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the Insurer or reducing your benefits under an existing policy or contract?  Yes  No  
 ii.) Are you considering using or borrowing funds from your existing policies or contracts to pay premiums due on the new or applied for policy?  Yes  No

If yes to either question, please complete and sign all required replacement forms and complete Question 62.

62. List all insurance in force on any Proposed Insured. If none, check this box.

Insured's Name & Company	Face Amount	Policy Number	Issue Year	Replacement or Change of Policy?	Check here if 1035 Exchange
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

Complete each question for the Proposed Owner, the Proposed Insured (if other than Owner) and any Additional Insured:

- |  | Proposed Insured, if other than Owner                                  | Additional Insured  | Proposed Owner  |
|--|--|---|---|
| 63. Have you been involved in any discussion about the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider? | a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | b) <input type="checkbox"/> Yes <input type="checkbox"/> No | c) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 64. Have you in the past two years sold a policy to a life settlement, viatical or other secondary market provider?  | a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | b) <input type="checkbox"/> Yes <input type="checkbox"/> No | c) <input type="checkbox"/> Yes <input type="checkbox"/> No |

If answered "YES" to any part of question 63 or 64, please give details for each "YES" answer.

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IX. GENERAL RISK INFORMATION	Proposed Insured	Additional Insured
65. In the past 3 years, have you smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?  If "Yes", last used (form)  Month, Year	a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
66. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard?  If "Yes", please list: branch of service, rank, duties, mobilization category and current duty station.	a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
67. In the past 3 years, have you engaged in, or within the next 12 months do you plan to engage in, flying in non-commercial aircraft; racing of any kind; skin or scuba diving; parachuting or sky diving; hang gliding; mountain, rock or technical climbing? If "Yes", complete Aviation/Avocation Supplement.	a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
68. Have you ever been convicted of a felony or misdemeanor (except for a minor traffic violation)?	a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
69. In the past 5 years, have you been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had your driver's license suspended or revoked?	a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
70. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No

If answered "Yes" to questions 66-70, please give details here for each Proposed Insured:

Proposed Insured:

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Additional Insured:

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#### X. MEDICAL INFORMATION

Proposed Insured:

71. Name/address/phone number of your personal physician and/or health care facility? (If none, indicate "None")  
Jeffrey Bednarik, 1671 S. Congress Ave., Ste 101, Ft. Lauderdale, FL 33461  
a. Date and reason last consulted? Feb 2007 - Check-up Tel 305-432-8933  
b. Treatment or medication prescribed?

72. Height 5 ft 1 in. Weight 185 lbs.

- a. Has your weight changed by more than 10 pounds during the past 12 months?  Yes  No  
b. If "Yes", by how many pounds? \_\_\_\_\_  Gain  Loss

Additional Insured:

73. Name/address/phone number of your personal physician and/or health care facility? (If none, indicate "None").

- a. Date and reason last consulted?  
b. Treatment or medication prescribed?

74. Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.

- a. Has your weight changed by more than 10 pounds during the past 12 months?  Yes  No  
b. If "Yes", by how many pounds? \_\_\_\_\_  Gain  Loss

Medical Information questions continue on next page.

**X. MEDICAL INFORMATION**

75. Have you ever had, or been told by a medical professional to seek treatment because of, any of the following:

- i. Chest pain, high blood pressure, heart attack, heart murmur, disease of the heart or blood vessels?
- ii. Cancer, tumor, leukemia, blood disorder, melanoma, or lymphoma?
- iii. Diabetes or high blood sugar?
- iv. Shortness of breath, asthma, sleep apnea, emphysema, tuberculosis, or other lung disease?
- v. Disease of the nervous system, stroke, seizure, paralysis?
- vi. Mental or nervous disorder, depression, anxiety?
- vii. Hepatitis, cirrhosis, or other disease of the liver or pancreas?
- viii. Ulcer, colitis, or other disorder of the stomach or intestines?
- ix. Disease or disorder of the kidneys, bladder or prostate, or a sexually transmitted disease?
- x. Arthritis disease or injury of the muscles, bones, or joints?
- xi. Any other health impairment, congenital deformity or medically or surgically treated condition not mentioned above?

76. Have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?

77. Have you ever been treated, or advised to receive treatment, for use of alcohol or drugs?

78. In the past 30 days, have you taken any medication or non-prescription drug?

79. Are you now planning to seek medical advice or treatment for any reason?

Proposed Insured	Additional Insured
a) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
a) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
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a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
a) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	b) <input type="checkbox"/> Yes <input type="checkbox"/> No

**Proposed Insured:**

80. Family Record	Age if Living	Present Health	Age at Death	Cause of Death
Father			40's	Leukemia
Mother			84	Stroke
Brothers				
Sisters				

**Additional Insured:**

81. Family Record	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

If answered "Yes" to questions 72, 74, 75-79, please give complete details including date of last treatment and name/address/phone number of the attending physician.

Proposed Insured: Dr Behrens - Glipizide 10mg, diabetes, metformin, arthritis, gabapentin 400mg, lisinopril 10mg BP

Additional Insured:

**XI. SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary)**

**XII. SECONDARY ADDRESSEE**

I elect to designate a secondary addressee.  Yes  No If "Yes," complete below.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**AGREEMENT AND ACKNOWLEDGEMENT**

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I Application; b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. Unless otherwise provided by the Conditional Receipt, the Company will have no liability under this application unless and until: a) it has been received and approved by the Company at its Service Office; b) the policy has been issued and delivered to the policyowner; c) the first premium has been paid to and accepted by the Company; and d) at the time of delivery and payment, the facts concerning the insurability of each person proposed for insurance are as stated in this application.
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
5. I ACKNOWLEDGE receipt of the Notices on the Medical Information Bureau and Fair Credit Reporting Act.
6. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I UNDERSTAND that any false statements or material misrepresentations may result in the loss of coverage under the policy.

**TO BE COMPLETED BY AGENT ONLY**

- (i) Do you know or have you any reason to believe that replacement of insurance is involved?  Yes  No  
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- (ii) I declare that I asked the Proposed Insured(s) each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application.
- (iii) I declare that I have accurately answered any questions contained in the Agent's Report completed by me in connection with this application.
- (iv) I declare that I have provided each Proposed Insured and Owner with the Notices on the Medical Information Bureau and Fair Credit Reporting Act as well as a copy of the Privacy Practices Notice.
- (v) I verified the Owner/Applicant's identity by viewing the individual's photograph on a driver's license, passport or other official document and have transcribed the number of such identification below. If applicant is a business or trust entity, I viewed documentation confirming the entity's legal status and state of formation.  
 Yes  No Driver's License, Passport or Other ID#: \_\_\_\_\_
- (vi) I declare I have not been involved in any discussion of the possible sale or assignment of the policy to a life settlement, viatical or other secondary market provider. If otherwise, please explain: \_\_\_\_\_
- (vii) I have verified that this policy will not replace a policy that has already been sold to a life settlement, viatical or other secondary market provider. If otherwise, please explain: \_\_\_\_\_

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**AUTHORIZATION**

Each of the undersigned declares that

I authorize any licensed physician, medical practitioner, hospital, clinic or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), state motor vehicle division, or other organization, institution or person that has any records or knowledge of,

Proposed Insured/Patient Shirley Friedberger Date of Birth 8/10/14

Proposed Additional Insured/Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

or the proposed insured's health, including but not limited to transaction records, employment records, financial records, and complete medical records (including information regarding insurance, demographics, referral documents and records from other facilities), motor vehicle information, or if other, indicate here:

to give all such information to Jefferson-Pilot Life Insurance Company or Jefferson Pilot Financial Insurance Company (the Company), their licensed representatives and/or their reinsurers, MediConnect.net Inc. G/S, or if other, indicate here \_\_\_\_\_

I understand that an authorization for release or disclosure of psychotherapy notes may not be combined with an authorization for release or disclosure of any other information (a separate Authorization Page must be completed for release or disclosure of psychotherapy notes).

I understand that the information obtained may be used by the Company to determine eligibility for insurance, or to administer my coverage. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurers to whom I have applied or may apply; 2) MIB; or 3) any other person or entity who performs business or legal services in connection with the administration of my insurance coverage. I understand that some of those people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

I have received a Privacy Practices Notice which details the method I must use to exercise my right to access, correct, and amend any information gathered about me or my children which relates to this application. I understand that I can provide written revocation of this Authorization to the Company at any time, except: 1) If the Company has taken action in reliance on the Authorization; or 2) the Company is using the Authorization in connection with a contestable claim under my policy.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application.

I agree that a copy of this authorization shall be as valid as the original and this authorization shall be valid for 24 months from the date shown below. I may have a copy upon request.

 I elect to be interviewed if an Investigative Consumer Report is prepared.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

**SIGNATORY SECTION**

Signed on \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_

(month)

(year)

Shirley Friedberger  
 Signature of Proposed Insured  
 (Parent or Guardian if under 18 years of age)

Signature of Proposed Additional Insured (if coverage accepted for)

Signature of Owner (if other than Proposed Insured)

Agent License Identification Number

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative

(Please Print)

I have reviewed the Application, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable

**BISYS Insurance Services, Inc.**

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NO. 2155 P. 3



## Please check appropriate underwriting company:

- Jefferson-Pilot Life Insurance Company, Service Office, PO Box 21008, Greensboro, NC 27420-1008  
 Jefferson Pilot Financial Insurance Company, Service Office, PO Box 515, Concord, NH 03302-0515  
(hereinafter referred to as "the Company")

**CONDITIONAL RECEIPT Part I - Return to the Company Service Office****This page must accompany the completed application.**

This Conditional Receipt provides a limited amount of life insurance coverage, for a limited period of time, subject to the terms of this receipt. This Conditional Receipt may not be given if the insuring age of any proposed insured is under 15 days or over 70 years of age (nearest birthday).

You cannot submit payment, nor give this Conditional Receipt, if you are submitting applications for alternate policies.

All checks must be made payable to Insurance Company checked above.

Do not make checks payable to the agent or leave the payee blank.

Name Proposed Insured

Name Additional Proposed Insured

Shirley Friedberger

(First) (Middle) (Last)

**Health Questions**

Have you:

1. Had or been treated for heart disease, stroke or cancer within the past twelve (12) months?

 Yes  No Yes  No

2. Been admitted to a hospital or other medical facility or been advised by a medical practitioner that you need to be hospitalized for any reasons other than for normal pregnancy within the past ninety (90) days?

 Yes  No Yes  No

Unless both questions are answered "No" for both insureds, payment cannot be submitted and the Conditional Receipt may not be given.

**SIGNATORY SECTION**

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ (month) \_\_\_\_\_ (year)

I have read the terms of this Conditional Receipt. I understand that the insurance applied for will not be effective unless and until all conditions of this Conditional Receipt are met. I have read and received a copy of Part II of the Conditional Receipt.

Shirley Friedberger  
Signature of Proposed Insured  
(Parent or Guardian under 14 years of age)

Signature of Proposed Additional Insured

Signature of Owner

Signature of Licensed Agent, Broker  
or Registered Representative Receiving Check Payable To Company



Please check appropriate underwriting company:

- Jefferson Pilot Life Insurance Company, Service Office: P.O. Box 21008, Greensboro, NC 27420-1008  
 Jefferson Pilot Financial Insurance Company, Service Office: P.O. Box 515, Concord, NH 03302-0515  
 (hereinafter referred to as "the Company")

### CONDITIONAL RECEIPT Part II

If payment is received, complete this page and leave with applicant.

The company acknowledges receipt of \$ \_\_\_\_\_ paid in connection with an Application for

Life Insurance dated \_\_\_\_\_, on Proposed Insured Shirley Friedberger

Additional Proposed Insured \_\_\_\_\_

Signature of Licensed Agent, Broker or Registered Representative Receiving Date  
 Check Payable To Company

#### Conditions and Limitations

**Amount Limitation - \$1,000,000 Total Insurance:** The maximum amount of life insurance which may become effective under this Conditional Receipt on any person proposed for insurance shall not exceed \$1,000,000 minus all life insurance provided under other Conditional Receipts and in force policies with the Jefferson Pilot Financial affiliated companies listed above. Life Insurance includes any benefits for accidental death.

#### Conditions:

- A minimum payment with application equal to one month premium for the insurance applied for must be made.
- Any check given in payment must be honored when first presented to the bank.
- All medical examinations and tests required by the Company's initial underwriting requirements must be completed and received at its Service Office during the lifetime of the Proposed Insured and prior to the Company's termination of the application, but in any case within 60 days from the completion of Part I of the application.
- If any person proposed for insurance dies by suicide or if the application or this receipt contains any material misrepresentations, then the Company's liability under this receipt is limited to a refund of the premium paid.
- Each person proposed for insurance must be a risk insurable on the beginning date in accordance with the Company's rules, limits and standards for the plan and the amount applied for without modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid.

**Beginning Date:** If all conditions in this receipt have been fulfilled, coverage under the policy applied for, subject to the Amount Limitations, may begin on the insurability date, which is the latest of (a) the date of completion of Part I of the application; or (b) the date of completion of all medical examinations, tests and other evidence required by the Company; or (c) the policy date, if any, requested in the application.

**Termination Date - 90 Day Maximum:** If the conditions have been met and coverage begins, coverage under this receipt will terminate 90 days from the date of this receipt unless prior to that date the insurance policy is issued and accepted.

If insurance is declined or the policy, if any, as issued is not accepted, any premium paid will be returned to the party(ies) that remitted the payment. If the policy is accepted, any premium paid will be credited to the premiums due under such policy.



Jefferson-Pilot Life Insurance Company, PO Box 21008, Greensboro, NC 27420-1008  
 Jefferson Pilot Financial Insurance Company, PO Box 515, Concord, NH 03302-0515  
 (hereinafter referred to as "the Company")

**AGENT'S REPORT** Date \_\_\_\_\_ (Completed Form Must Accompany Application for Life Insurance)

**GENERAL INFORMATION**

1. (i) Name of Owner/Applicant <u>The Friedberger Irrevocable Ins. Trust</u>	(ii) Name of Insured(s) <u>Shuliey Friedberger</u>
(iii) How long and how well have you known the Proposed Insured(s) and Owner? <u>Daughter is client for 1st years</u>	
2. Are you related to the Proposed Insured(s)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", Give details:	
3. Do the Proposed Insured(s) and Owner read and understand the English Language? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", how was the application completed?	
4. If LifeComp program was used, have you completed the required paperwork? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
5. Answer only if Proposed Insured is under age 15.	
a. Father's Life Insurance: Amount In Force: \$	Amount Applied for: \$
b. Mother's Life Insurance: Amount In Force: \$	Amount Applied for: \$
c. Are siblings also being insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain:	

**BUSINESS FINANCES** (Complete only if this is business insurance)

6. Type of business: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other:		
7. Proposed Insured is: <input type="checkbox"/> Employee <input type="checkbox"/> Owner of % of business		
8. Total Business Assets: \$	Total Business Liabilities: \$	Total Business Net Worth: \$
9. Net Income (Profit) for the past 2 years: Last year \$	Previous year \$	
10. Is application signed by authorized officer or partner other than Proposed Insured? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", please explain:		

11. Are applications being submitted on other business associates?  Yes  No

12. What insurance does the business maintain on the lives of each corporate officer/key person/partner and the amount of business insurance on each?

Name	Title	% of Ownership	Amount In Force	Amount Applied For
			\$	\$
			\$	\$
			\$	\$
			\$	\$

**AGENT INFORMATION**

13. Agents who participated in this application:

Full Name of Agent entitled to commission:	Agent Number	% Comm. Share	Agent's Phone Number: (include area code)	Agent's Fax Number: (include area code)
<u>Michael L. Binday</u>	<u>Pending</u>	<u>100 %</u>	<u>REDACTED</u>	<u>REDACTED</u>
		%		
		%		

14. Primary Agent's E-Mail Address: m.binday@advhr.com

15. Identify any special compensation instructions (i.e. trail commission schedule) or  Check here if there is no special commission program:

